Personal Care Provider Conference Call Questions

March 18, 2014

1. When forms are updated or revised, it would be helpful if the date of the revision was on the form. Would that be possible?

Answer: Current forms are on the website. We have recently made changes (primarily formatting) to the Member Assessment, Plan of Care, Monthly Report, RN Initial Contact Log and the Transfer Form. Yes, we will start adding the revision date to the bottom of the forms. In fact, we have already done so with the ones listed above after we received your suggestion. All current forms are on the Bureau for Medical website at www.dhhr.wv.gov/bms Anytime a form is updated or revised, you will be notified via email from the Bureau of Senior Services.

2. On page 2 of the "Definitions of the Personal Care Terms", it states, "Routine skin care such as applying body lotion after bathing or application of suntan lotion is not considered medically necessary". We feel it is medically necessary especially if an individual is on diuretics, if they are not mentally capable of applying lotion, or if they are obese and not able to reach certain areas. Is applying lotion allowed to be used on the Plan of Care or not?

Answer: Yes, but not as a "routine" item on the Plan of Care. There must be a medical/clinical basis for application of lotion and it must be documented.

3. If you receive a prior authorization after the beginning of the month with an authorization date (anchor date) of the beginning of the month, when is the first date for which you can bill hours? The anchor date or the date of receipt?

Answer: The anchor date.

4. Can you use the previous logs in 2014 if you received approval for hours in December for services beginning in January? Or is the new form required?

Answer: We are not sure what you are referring to when you state "logs". If you want to resubmit your question with more specific language please do so. As for forms, they are to be utilized as of the effective date of the manual (January 1, 2014). Use them as they come due for each individual member (Plan of Care, Member Assessment) or as they are needed for individual members (Transfer Form, Discontinuation of Services, etc.).

5. Can ADL's and IADL's that are assigned a specific day be changed to a different day if the direct care worker notates why and would it be able to be billed?

Answer: This question was addressed on the last conference call on February 18, 2014. Please refer to that document – it is question/answer #3 and question/answer #15. The document is posted on the Bureau of Senior Services website at www.wvseniorservices.gov and the Bureau for Medical Services website at www.dhhr.wv.gov/bms

6. Why can't we save information that we type on the Plan of Care?

Answer: You can save information on the Plan of Care. It has been tested both internally as well as with selected providers. If you are unable to save, it may be a technology issue on your end such as outdated software.

7. Can you please add provider name to the top of the Plan of Care?

Answer: The form was developed specifically with the member's name because it is the member's Plan of Care. If you want, you can write your agency name somewhere on the form.

8. Can you please confirm that you can bill two T1001 events in one year?

Answer: Yes, but this is currently being addressed by the Bureau for Medical Services with Molina so that this is permissible. The billing must be at least 300 days apart. If you have billing that is denied due to this, contact Susan Given at Susan.A.Given@wv.gov

9. If a request for Level 2 has been denied due to lack of points to substantiate Level 2, why do I need to resubmit a request for Level 1?

Answer: If you submit for a Level 2 and they don't meet Level 2 criteria but they do meet Level 1 criteria, they will be approved for Level 1. They will also get a Notice of Decision from APS Healthcare informing them that they have been denied at Level 2 and that notice will include a Request for Hearing form.

10. If the RN Assessment and the Plan of Care are not completed before the PAS has been approved, how can you submit for Level 2 Services?

Answer: You can't, these documents are required for a Level 2 prior authorization.

11. I have a member who was approved for extended hours for 80 hours a month. This approval was done in 2013. Now the member needs more time. Can I just go ahead and increase the hours up to the maximum of 210?

Answer: Yes, as long as it is medically/clinically justified and documentation supports that justification.

12. If a member transfers to us and he was receiving extended hours, but our agency RN feels under her professional opinion that the member only qualifies for a Level One, should this not be reported as potential abuse of the program?

Answer: Yes, this should be reported to Medicaid Recipient Fraud (304-558-1970) as well as Medicaid Fraud (304-558-1858). You should only provide the hours the person actually needs despite the LOC – the RN needs to document the situation.

13. What does the Tr stand for on a member's medical card after their 11 digit Medicaid #? I've seen this on cards and when I call EDI I am told it is a QMB card. We cannot provide Personal Care if all they have with Medicaid is QMB, correct?

Answer: Tr stands for Traditional Medicaid. For a while, Medicaid had traditional, enhanced and basic. All Medicaid is now traditional. So, you will see this on cards that are QMB as well. QMB cards will not cover Personal Care services.

14. According to policy, a felony offense prohibits a direct care worker from working (in the direct care worker field) if the offense was within the last 10 years. Policy also dictates that a direct care worker cannot work at all (in the caregiving) field if there is a CPS/APS substantiation of maltreatment. This seems inequitable. Why should a direct care worker be punished forever for an offense that carries no legal penalty but be excused after 10 years for a legal offense of the highest level?

Answer: The only offenses listed in Medicaid policy that has the 10 year limitation is felony DUI and felony drug related offenses. There is a process for individuals to apply to DHHR to request findings be removed from their DHHR Protective Services Record Check. Information on how to do this was sent out via email to providers last week.

15. It would be very helpful and less time consuming for providers if the name of the member was on the Personal Care Prior Authorization instead of just the Medicaid number. Is that possible?

Answer: Yes, APS Healthcare will add the person/member's name to the prior authorization. Please ensure HIPAA compliance with any communication regarding Protected Health Information (PHI).

16. Can we get a step-by-step form that states what documents/forms need to be submitted with prior authorizations and dual services?

Answer: The APS Healthcare fax sheets for prior authorizations and dual services include exactly what you need to submit.

17. In late January, I submitted a PAS to APS Healthcare that was due in mid-February. I was under the assumption the anchor date would be in February since that was when it was due previously but when I received it back the anchor date was 1/1/14.

Answer: The anchor date will be the first day of the month in which APS Healthcare approved the prior authorization.

18. I called APS about a PAS that I had sent approximately 30 days before its expiration. I was told that we did not need to send it in that early.

Answer: You can and should submit up to 60 days before the expiration.

19. Due to severe weather the past couple of months, some direct care workers have not been able to work their regular schedules. I am concerned that environmental could be over the one-third allowed.

Answer: The Bureau of Senior Services RN monitors review environmental based on the billing period, not on a daily basis.

20. On the Member Assessment, where do we get the financial eligibility date?

Answer: That is the date you verify financial eligibility. Providers due this in different ways such as by looking at the card or by calling their local DHHR office.

21. There are some missing items on the Plan of Care – doing dishes, care of medical equipment, vital signs, etc.

Answer: A couple of items have been added (such as dishes). If there is a specific item not on there, you can use the comment section. Doing vital signs is not a policy requirement but you can do them if you choose.

22. If a Level 1 PAS and Member Assessment were done prior to January 1, 2014 and there is no Physician Certification Form available (because it was done before the new policy). If there are changes with the member that the RN feels justifies a Level 2, what must be submitted to WVMI?

Answer: This question was answered on the February 18, 2014 conference call. Refer to Question/Answer #1. If the RN was the one who completed the PAS, you would have to get a Physician Certification Form.

23. Can I get paid for a Plan of Care developed before the anchor date starts?

Answer: Not for initials because they are not yet medically eligible. Yes, for re-evaluations because they have current medical eligibility.

24. Why does WVMI send back the entire PAS? It is wasting our paper. Sending back just the correction request would be sufficient.

Answer: WVMI must send back the entire PAS. Please thoroughly check your PAS for accuracy before submitting to eliminate WVMI having to return it.

25. With daily schedules being fluid, why do we have to assign specific times for the worker? It would be easier to document the time after the fact rather than before.

Answer: Please refer to Question/Answer # 3 and #15 from the 2/18/14 conference call. This is a planned service and services must be scheduled.

26. If a member is totally bedbound and is only transferred with a hydraulic lift, why can't #26 i (walking) on the PAS be marked n/a?

Answer: Yes, you can mark N/A. Or you can write in something that explains the situation such as non-ambulatory. Putting something in the field assures our RN monitors that it wasn't a field that was overlooked by accident – it informs them that the field actually doesn't apply to this person for a specific reason.

27. During the last call, it was stated that all prior authorizations in place prior to the start of the new manual were automatically approved until their PAS is due again. Does this hold true for dual services as well?

Answer: Yes.

28. Does the UMC send the individual/member notification of approval or denial for services and what Service Level they are? Do they get a copy of their PAS?

Answer: The Bureau for Medical Services does not require that the UMC send approval notices to members for Personal Care services. In the event that a member is denied either eligibility for Personal Care or requested Level of Care (e.g. request is for Level 2 but member can only be approved for Level 1) the member will be sent a Notice of Decision with information about their Fair Hearing Rights and a copy of their Pre-Admission Screening assessment. Approvals are communicated to the provider of service via authorization correspondence. If the member requests a copy of their PAS or information about their approval, the provider should accommodate the request.

Program Updates:

1. Make sure you are using the PAS on the Bureau for Medical Services website.
2. Several forms have been updated and the revision dates are on the bottom of the forms. They are located on the Bureau for Medical Services website.
3. If you have a member who is a Level 1 that needs a Level 2, a new PAS does not need to be done.
4. If you have a prior authorization that was prior to the implementation of the new manual (1/1/14), the prior authorization is good until the PAS expires.
5. Regarding the Molina provider enrollment/re-validation process. The asked for "approval" letters from BoSS. We have done those letters for each provider and electronically sent them to Molina. We also mailed you a copy of your letter. If you have questions about what Molina needs for your NEMT, you need to contact them or your local DHHR to discuss. BoSS does not administer NEMT services for Medicaid.

Next Conference Call: April 15, 2014 11am